DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/27/2019 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED		
		445172	B. WING			1	R / 25/2019	
	PROVIDER OR SUPPLIER	REHABILITATION-SMITH COUNT		STF 112	REET ADDRESS, CITY, STATE, ZIP CODE HEALTH CARE DR RTHAGE, TN 37030	1111	20/20 13	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOU		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE	(X5) COMPLETION DATE	
{K 000}	INITIAL COMMENT During the follow u 11/25/2019, all prev were corrected.	p survey conducted on riously cited Federal citations	{K 0	00}				
ABODATORY	DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIG	NATURE		TITLE		(X6) DATE	

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH	AND HUMAN SERVICES
CENTERS FOR MEDICARE	& MEDICAID SERVICES
	WAY BROWINED/CLIBBLIED/CLIA

FORM APPROVED OMB NO. 0938-0391

(X2) MULTIPLE CONSTRUCTION

A BUILDING 01 - MAIN BUILDING 01

(X3) DATE SURVEY COMPLETED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

IDENTIFICATION NUMBER:

445172

B WING

09/25/2019

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

112 HEALTH CARE DR CARTHAGE, TN 37030

(X4) ID PRÉFIX TAG

SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

CONCORDIA NURSING AND REHABILITATION-SMITH COUNTY

ID PREFIX TAG

K 000

PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS REFERENCED TO THE APPROPRIATE DEFICIENCY)

(X5) COMPLISTION DATE

K 000 INITIAL COMMENTS

Stories: 2

Construction Type: NFPA, III (111) Limited plans available on site

Constructed: 1982 Sprinklered: Yes Certified beds: 124 Census: 91

A Life Safety Code Survey was conducted by the State of Tennessee Department of Health Division of Health Licensure and Regulations Office of Health Care Facilities on 06/23/2019. During this Life Safety Survey, Concordia Nursing and Rehabilitation-Smith County was found not in substantial compliance with the requirements for participation in Medicare/Medicaid with Title 42 CFR Subpart 483.70(a), The Rules of Tennessee Department of Health Board for Licensing Health Care Facilities Chapter 1200-08-06 Standards For Nursing Homes, and National Fire Protection Association (NFPA) 101 Life Safety (2012 Edition).

K 321 Hazardous Areas - Enclosure SS=D CFR(s): NFPA 101

> Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches

K 321

- 1. On 9/23/19 the Maintenance Director closed the kitchen storage room door.
- 2. All residents had the potential to be affected, but no residents were affected.
- 3. On 9/24/2019 Administrator and Director of Nursing educated the Maintenance Director and his assistant on the regulations pertaining to Hazards Areas-Enclosure.
- 4. Administrator and Maintenance Director will monitor compliance using an audit tool 3 X a week for 1 month, 2 X a week for 1 month, 1 X a week for an additional month. Any findings will be conveyed to the monthly QAPI meeting for 3 months.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

Facility ID: TN8001

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				1	0938-0391
TATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MUL A BUILD	TIPLE ING 01	CONSTRUCTION - MAIN BUILDING 01		TE SURVEY MPLETED
		445172	B WING		agranded to the second of the	09	/25/2019
	PROVIDER OR SUPPLIER	REHABILITATION-SMITH COUNT	Y	112	RTHAGE, TN 37030		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	ノビに	(X5) COMPLETION DATE
K 321	Describe the floor a	R OR SUPPLIER JRSING AND REHABILITATION-SMITH COUNTY SUMMARY STATEMENT OF DEFICIENCIES ACH DEFICIENCY MUST 0E PRECEDED BY FULL GULATORY OR LSC IDENTIFYING INFORMATION) Mued From page 1 he bottom of the door. ibe the floor and zone locations of dous areas that are deficient in REMARKS. 1, 19,3.5.9 Automatic Sprinkler aparation N/A ler and Fuel-Fired Heater Rooms indries (larger than 100 square feet) hair, Maintenance, and Paint Shops led Linen Rooms (exceeding 64 gallons) shousible Storage Rooms/Spaces 50 square feet) ioratories (if classified as Severe d - see K322) IEQUIREMENT is not met as evidenced d on an observation, the facility failed to ain hazardous areas. Inding included: vation on 09/23/2019 át 10:06 AM, revealed chen storage room door was propped open in unapproved system. 101, 19.3.2.1.3 (2012 Edition) anintenance director was present for the is which were later acknowledged by the istrator during the exit conference on 2019 gg Facilities STREET ADDRESS, CITY, STATE, Z Int PROVIDERS DATE (ARTH CARE DR CARTHAGE, TN 37030 STREET ADDRESS, CITY, STATE, Z Int PROVIDERS DATE, STATE, Z Int PROVIDERS STREET ADDRESS, CITY, STATE, Z Int PROVIDERS DATE, STATE, Z Int PROVIDERS					
	Separation N/A a. Boiler and Fuel-F b. Laundries (larger c. Repair, Maintena d. Soiled Linen Roc e. Trash Collection (exceeding 64 gallo f. Combustible Stor (over 50 square fee g. Laboratories (if c Hazard - see K322) This REQUIREMEN	Fired Heater Rooms than 100 square feet) ince, and Paint Shops ims (exceeding 64 gallons) Rooms ins) age Rooms/Spaces it) lassified as Severe					
	maintain hazardous	s areas.					
	Observation on 09/2 the kitchen storage with an unapproved	23/2019 át 10:06 AM, revealed room door was propped open l system.	y y				
K 324 SS=D	findings which were administrator during 09/23/2019 Cooking Facilities	later acknowledged by the	K3	324			
	Cooking Facilities Cooking equipment	is protected in accordance			W a reali		heel Page 2 of (

DEPARTMENT OF HEALTH AND HUMAN SERVICES

FORM APPROVED

OMB NO 0938-0391

DEPART	MENT OF HEALTH	AND HUMAN SERVICES		C	FORM APPROVED OMB NO 0938-0391
CENTERS FOR MEDICARE & MEDICA STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDE IDENTIFICE IDENTIFICE (X2) PROVIDE IDENTIFICE (X3) PROVIDE IDENTIFICE (X4) PROVIDE IDENTIFICE (X5) PROVIDE IDENTIFICE (X6) PROVIDE IDENTIFICE (X6) PROVIDE IDENTIFICE (X7)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING 01 - MAIN BUILDING 01		(X3) DATE SURVEY COMPLETED
		445172	B WING		09/25/2019
	PROVIDER OR SUPPLIER	REHABILITATION-SMITH COUNT	, 1 ₁	TREET ADDRESS, CITY, STATE, ZIP CODE 12 HEALTH CARE DR ARTHAGE, TN 37030	NI (VE)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETION
	and Fire Protection Operations, unless: * residential cooking appliances such as toasters) are used f cooking in accordar * cooking facilities of compartments with with the conditions of * cooking facilities in 30 or fewer patients 18.3.2.5.4, 19.3.2.5 Cooking facilities pr per 9.2.3 are not rechazardous areas, b corridor. 18.3.2.5.1 through 19.3.2.5.5, 9.2.3, Ti This REQUIREMEN by: Based on an obser maintain the kitcher The findings include Observation on 09/2 1 of 4 hood suppres missing. NFPA 101, 19.3.2.5 10.2.6 (2011 Edition Edition)	dard for Ventilation Control of Commercial Cooking g equipment (i.e., small microwaves, hot plates, for food warming or limited nee with 18.3.2.5.2, 19.3.2.5.2 open to the corridor in smoke 30 or fewer patients comply under 18.3.2.5.3, 19.3.2.5.3, in smoke compartments with comply with conditions under 14. The contested according to NFPA 96 quired to be enclosed as ut shall not be open to the 18.3.2.5.4, 19.3.2.5.1 through A 12-2 IT is not met as evidenced vation, the facility failed to hood suppression system.	K 324	 On 9/27/2019 the Maintenance replaced the missing hood supprenozzle cap. All residents had the potential traffected, but no residents were affected, but no residents were affected. On 9/24/2019 Administrator and Maintenance director and his assistant on the repertaining to Cooking Facilities. Administrator and Maintenance will monitor compliance by utilizin audit tool 3 x week for 1 month, 2 for 1 month and 1 x week for I monthings will be brought to the month QAPI meeting for 3 months. 	o be fected. d Director ance egulations e Director g an x week onth. Any onthly
	7(02-99) Previous Versions		1 Fac	cility ID: TN8001 If contin	nuation sheet Page 3 of 6

DEPAR	TMENT OF HEALT	H AND HUMAN SERVICES			FORM APPROVED OMB NO. 0938-0391
STATEMEN	RS FOR MEDICAL FOR DEFICIENCIES DE CORRECTION	(X1) PROVIDER/SUPPLIER/GLIA IDENTIFICATION NUMBER:	(X2) MULTIF A BUILDING	LE CONSTRUCTION 6 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED
		445172	B WING		09/25/2019
	PROVIDER OR SUPPLIE	REHABILITATION-SMITH COUNT		STREET ADDRESS, CITY, STATE, ZIP CODE 112 HEALTH CARE DR CARTHAGE, TN 37030	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION
K 324	Continued From p		K 324	1	9
	findings which we	re later acknowledged by the ng the exit conference on			
K 353 SS=D	Sprinkler System Automatic sprinkler inspected, tested, with NFPA 25, States Testing, and Main	- Maintenance and Testing er and standpipe systems are and maintained in accordance andard for the Inspection, taining of Water-based Fire	K 350	Director had Johnson Controls Co- conduct the 3-year air leakage te- for the Dry Pipe Fire Sprinkler Sy- On 10/02/2019 the Maintenance I received a copy of the 3-year Full Trip Test for the Dry Pipe Fire Sp System that was completed on 4/ by Simplex Grinnell. On 10/02/20	ompany st stem. Director I Flow rinkler 23/2019
	Protection Systen maintenance, insp maintained in a se available. a) Date sprinkler	received a copy of the 3-year Full Trip Test for the Dry Pipe Fire Spr System that was completed on 4/2 by Simplex Grinnell. On 10/02/2019 the Maintenance Director had Joh Controls Company conduct the 10 Dry Pendant Test for the Dry Pipe Sprinkler System. On 10/02/2019 Maintenance Director received a copy of the 3-year Full Trip Test for the Dry Pipe Fire Spr System that was completed on 4/2 by Simplex Grinnell. On 10/02/2019 the Maintenance Director had Joh Controls Company conduct the 10 Dry Pendant Test for the Dry Pipe Sprinkler System. On 10/02/2019 Maintenance Director received a copy of the 3-year Full Trip Test for the Dry Pipe Fire Spr System that was completed on 4/2 by Simplex Grinnell. On 10/02/2019 the Maintenance Director had Joh Controls Company conduct the 10 Dry Pendant Test for the Dry Pipe Sprinkler System. On 10/02/2019 Maintenance Director received a copy of the 3-year Full Trip Test for the Dry Pipe System that was completed on 4/2 by Simplex Grinnell. On 10/02/2019 the Maintenance Director received a copy of the 3-year Full Trip Test for the Dry Pipe System that was completed on 4/2 by Simplex Grinnell. On 10/02/2019 the Maintenance Director received a copy of the 3-year Full Trip Test for the Dry Pipe System that was completed on 4/2 by Simplex Grinnell. On 10/02/2019 the Maintenance Director received a copy of the Maintenance Director had Joh Controls Company conduct the 10 Dry Pendant Test for the Dry Pipe System that was completed on 4/2 by Simplex Grinnell. On 10/02/2019 the Maintenance Director received a copy of the 3-year Full Trip Test for the Dry Pipe System that was completed on 4/2 by Simplex Grinnell. On 10/02/2019 the Maintenance Director received a copy of the Maintenance Director had Joh Controls Company conduct the 10 Dry Pendant Test for the Dry Pipe System that was completed on 4/2 by Simplex Grinnell.	0 year e Fire the copy on for s		
	,			Grinnell. 2. All residents had the potential affected, but no residents were at	to be ffected.
	c) Water system supply source Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on document review, the facility failed to maintain the fire sprinkler system.	 On 9/24/2019 the Administrato Director of Nursing educated the Maintenance Director and his asson the regulations pertaining to the sprinkler system. Administrator and Maintenance will monitor compliance via the "F System, Life Safety Monitoring To and will ensure requirements are conveyed to the monthly QAPI m for 3 months. 	sistant ne e Director Reqqer" ool,		
	The findings inclu				
	AM and 9:53 AM, the Air leakage te system within the NEPA 101, 19:3.5	ew on 9/23/2019 between 9:00 revealed no documentation for st for the dry pipe fire sprinkler last 3 years. 1 (2012 Edition), NFPA 101, ion), NFPA 13, 24.6.1 (2010			

DEPARTMENT OF HEALTH				OMB NO. 0938-0391
CENTERS FOR MEDICARE	& MEDICAID SERVICES	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA (DENTIFICATION NUMBER:		01 - MAIN BUILDING 01	COMPLETED
	445172	B WING		09/25/2019
NAME OF PROVIDER OR SUPPLIER CONCORDIA NURSING AND I	REHABILITATION-SMITH COUNT	1	TREET ADDRESS, CITY, STATE, ZIP CODE 12 HEALTH CARE DR CARTHAGE, TN 37030	
(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS REFERENCED TO THE APP DEFICIENCY))(JLD BE COMPLETION
K 353 Continued From particles Edition), NFPA 25, 2. Document review AM and 9:53 AM, restricted the full flow trip test system within the land NFPA 101, 19.3.5.1, 9.7.1.1 (2012 Edition), NFPA 25, 3. Document review AM and 9:53 AM, restricted the full flow trip test system. NFPA 101, 19.3.5.1, 9.7.1.1 (2012 Edition), NFPA 25, 4. Document review AM and 9:53 AM, resinspection for the fill flow for the fill flow for the fill flow flow for the fill flow flow flow for the fill flow flow flow flow flow flow flow fl	ige 4 13.4.4.2.9 (2011 Edition) v on 9/23/2019 between 9:00 evealed no documentation for for the dry pipe fire sprinkler ast 3 years. (2012 Edition), NFPA 101, on), NFPA 13, 24.6.1 (2010 13.4.4.2.2.2 (2011 Edition) v on 9/23/2019 between 9:00 evealed no documentation for dant test for the dry pipe fire (2012 Edition), NFPA 101, on), NFPA 13, 24.6.1 (2010 5.3.1.1.1.6 (2011 Edition) v on 9/23/2019 between 9:00 evealed no backflow re sprinkler system within the (2012 Edition), NFPA 101, on), NFPA 13, 24.6.1 (2010 13.3.3.1 (2011 Edition) irector was present for the	K 353		
administrator during 09/23/2019	e later acknowledged by the g the exit conference on ection & Testing - Doors	K 761		
Fire doors assembl annually in accorda for Fire Doors and	ection & Testing - Doors ies are inspected and tested nce with NFPA 80, Standard Other Opening Protectives. cluding corridor doors to			
DAA CAAS 2567(02-99) Previous Versions	Obsolete Event ID: XM112	21 Fa	cility ID: TN8001	ontinuation sheet Page 5 of 6

DEPARTMENT OF HEALTH AND HUMAN SERVICES

DEPAR	TMENT OF HEALTH	AND HUMAN SERVICES			FORM APPROVED DMB NO. 0938-0391
STATEMEN	RS FOR MEDICARE T OF DEFICIENCIES OF CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED
		445172	B WING		09/25/2019
	PROVIDER OR SUPPLIER	REHABILITATION-SMITH COUNT		STREET ADDRESS, CITY, STATE, ZIP CODE 112 HEALTH CARE DR CARTHAGE, TN 37030	
(X4) ID PREFIX TAG	/EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE COMPLETION
K 761	routinely inspected maintenance progra Individuals perform testing possess know that demonstrates a Written records of it maintained and are 19.7.6, 8.3.3.1 (LSC 5.2, 5.2.3 (2010 NFThis REQUIREMENTS). Based on documer inspect protective on The finding included Document review of AM and 9:53 AM, rea fire damper inspect NFPA 101, 19.1.1.2 4.2.1 (2012 Edition) Edition), NFPA 101, 80, 19.4.1.1 (2010 Edition) The maintenance diffindings which were	smoke barrier doors, are as part of the facility am. Ing the door inspections and owledge, training or experience ability. Inspection and testing are available for review. C) PA 80) IT is not met as evidenced at review, the facility failed to penings. d: In 09/26/2019 between 9:00 evealed no documentation for ction within the last 4 years. (2012 Edition), NFPA 101, NFPA 101, 4.4.2.1 (2012 8.2.2.4 (2012 Edition), NFPA		1 1. On 10/07/2019 the Maintenance Director Cookeville Heating and Cooling Company of a 4-year Fire Damper Inspection Test. 2. All resident had the potential to be affected no residents were affected. 3. On 9/24/2019 the Administrator and Director Nursing educated the Maintenance Director is assistant on the regulations pertaining to Maintenance Inspection and Testing-Doors. 4. Administrator and Maintenance Director is assure compliance by using the "Reqqer" Surfe Safety Monitoring Tool and will ensure regulations are conveyed to monthly QAPI meeting for 3 months.	onduct ed, but ctor tor and) will ystem,

DEPART	MENT OF HEALT	H AND HUMAN SERVICES RE & MEDICAID SERVICES			FORM APP OMB NO. 093	
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		
		445172	B WING		OMB NO. 0938- (X3) DATE SURVI COMPLETED 09/25/201	2019
	PROVIDER OR SUPPLIE	REHABILITATION-SMITH COUN	112	REET ADDRESS, CITY, STATE, ZIP CODE HEALTH CARE DR RTHAGE, TN 37030		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	DED BE COL	(X5) MPLETIC DATE
E 000	Initial Comments		E 000			
	During the annua survey conducted were cited.	al emergency preparedness on 09/23/2019, no deficiencies	3			
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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